HFP
Business Rules

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1. Eligibility Requirements for Children:

- Children up to their 19th birthday.
- Families with incomes at or below 250% of the Federal Income Guidelines (FIG).

  The FIG is updated annually, effective April 1st, and are transmitted to HFP from MRMIB. HFP is to use the new FIGs for all applications received at Single Point of Entry on or after April 1st of each year.

  Children ages 0 up to the age of 1 with incomes over 200% and equal or less than 250%.

  Children ages 1 through 5 with incomes over 133% and equal or less than 250%.

  Children ages 6 through18 with incomes over 100% and equal or less than 250%.

- Children without employer-sponsored health insurance in the last 3 months, or children who had employer-sponsored insurance within the last three months that ended due to:
  - The person or parent providing health coverage lost a job or changed jobs; or
  - The family moved into an area where employer-sponsored coverage is not available; or
  - The employer discontinued health benefits to all employees; or
  - Coverage was lost because the individual(s) providing the coverage died, legally separated, or divorced; or
  - Health coverage was provided under a federal Consolidated Omnibus Budget Reconciliation Act (COBRA) policy, and the COBRA coverage ended; or
  - The person reached the maximum coverage of benefits allowed in the current insurance in which the person is enrolled.
- Children not eligible for no-cost Medi-Cal or children who have Medi-Cal with a share of cost and that meet income requirements listed above.
- AIM-linked infant who was born through the AIM Program where the pregnant woman was found eligible for (not effective date of coverage) the AIM Program on or after July 1, 2004. Refer to the AIM Business Rules regarding the enrollment process for the AIM-linked infants into the HFP.
- Children who are U.S. citizens, nationals, or eligible qualified immigrants.
  - All eligible qualified immigrants must provide acceptable and un-expired immigration documentation.
  - All eligible U.S. citizens and nationals must provide acceptable citizenship documentation; unless there is an acceptable birth record match with the State of California Department of Vital Statistics.

- Children who live in California.

2. Pre-enrollment for Unborn Babies:

- A pregnant woman with income between 200% and 250% may apply for HFP coverage for her baby up to 3 months before her due date.

  When the child is born, an applicant must submit documentation of the child's birth to the program, and must include the child's name, place and date of birth, and gender. The documentation and information must be received by the program within thirty (30) days from the birth of a child. Acceptable forms of documentation include a certificate of birth provided by a hospital or other health care facility, a signed statement by the health practitioner who presided over the delivery, or an equivalent document. Coverage begins no later than 13 calendar days from the receipt of the certificate of birth.

Note: A child enrolled in HFP who subsequently becomes pregnant will remain in the HFP through her anniversary date. Her pre-natal care, as well as, the delivery will be covered by HFP. She will remain covered and enrolled in the HFP but the baby would not automatically be enrolled in the HFP. A pregnant teen is not eligible for HFP during AER and will be forwarded to Medi-Cal.

3. Pre-Enrollment for Children:

Pre-enrollment into the HFP is available only to children who are currently enrolled in a Medi-Cal percentage program and have a Notice of Action (NOA) stating that their coverage will terminate upon reaching age 1 or age 6. If these children are eligible for the HFP, they will be assigned a future effective date. Children who are not currently enrolled in a Medi-Cal percentage program and appear to qualify for no-cost Medi-Cal shall be forwarded to no-cost Medi-Cal. Accelerated Enrollment (AE) shall be established for the child if all other AE eligibility requirements are met.

- An applicant may apply for HFP in advance for persons who are not eligible at the time of application, but who the applicant believes will become eligible within three (3) months because of the following:

  (a) They are currently enrolled in the Medi-Cal 200% Program and will become one year old.

  (b) They are currently enrolled in the Medi-Cal 133% Program and will become 6 years old.

  (c) They are currently on Medi-Cal for at least one month of continued eligibility under no cost, full scope Medi-Cal and have been notified by the County Department of Social Services that coverage is ending.

4. Who Can Be A HFP Applicant:

- Parents (natural or adoptive);
- Legal Guardians;
- Step-parents;
- Foster parents;
- Caretaker relatives;
- Minors not living with persons listed above;
- Person 18 years of age who are applying for coverage for himself/herself.

Note: If the child is listed in Section 1 and also listed in Section 2 of the application, and if the parent who lives in the home (as identified in Section 2) signed the application, the HFP will make the parent, who lives in the home and who signed the application, the applicant. In this particular circumstance, the application will be sent to call back to obtain the missing information of the applicant (i.e. applicant's date of birth, income documentation or other missing information). The first page of the application will not have to be re-submitted by the applicant.

5. Splitting Applications:

Any time the HFP creates separate MFBUs (from the same application) and it is determined that the applicant cannot apply for the person in the separate MFBU, a letter (along with a form to be signed by the appropriate applicant for the person(s) in the separate MFBU) will be sent requesting permission to continue the application process. A new application will not be required. Once the HFP received the signed form, a new Family Member Number will be created for the separate MFBU.

6. Who Can Be An Authorized Representative:

An Authorized Representative (AR) is a Certified Application Assistant (CAA) of an Enrollment Entity (EE) or a person or organization, such as a, Health Care Advocate, legal aid firm, etc, who can assist the applicant in their inquiry at initial application, annual eligibility review, request for re-enrollment, continued enrollment, program review and 1st level appeal. The Representative's assistance is limited to resolution of the specific issue and is not a Representative for on going case management. The time frame begins when the HFP receives the AR form signed by the applicant and ends when the HFP mails the results of the determination or decision. Eligibility status or case outcome may be provided to EEs and CAAs that have been designated as the AR. This means the AR is allowed to communicate, on behalf of the applicant, with the HFP on the appeal, request for continued enrollment or program reviews for up to 15 business days, initial applications and re-enrollments for up to 20 calendar days, annual eligibility reviews up until the disenrollment date, Authorized Representative(s) must be identified on the system. (i.e., Nature of inquiry etc.)

7. What to do with Duplicate Applications:

When more than one application is received for a client who is eligible for Healthy Families, the disposition of each application needs to be updated on MEDS. (e.g., one approved and the other application denied.)

8. Beginning Date of Coverage:

(a) Coverage shall begin for subscribers no later than ten (10) calendar days from the date the person is determined to be eligible unless any of the following applies:

(1) A person for whom the application is being made is eligible for continued eligibility under no-cost, full scope Medi-Cal, including CHDP Gateway and that eligibility will continue for more than ten (10) calendar days from the date the person is determined eligible.
(2) Application is being made on behalf of a child less than 12 months of age who is enrolled in the Medi-Cal 200% program.
(3) Application is being made on behalf of a child who is currently enrolled in the Medi-Cal 133 percent program.
(4) Application is being made on behalf of a newborn prior to birth.
(5) Payment of in arrears family contributions is required prior to enrollment of the person pursuant to Section 2699.6600(a)(4) or (5).

(b) Coverage shall begin for subscribers under (a)(1 - 3) on the first day of the month after the end of the subscriber's Medi-Cal eligibility. A Notice of Action, which is dated within two (2) months of application, end date may be used to override 611 codes.
(c) Coverage shall begin for subscribers under (a)(4) no less than eleven (11) calendar days but within thirteen (13) calendar days after the program receives documentation of the birth.
(d) Coverage shall begin for subscribers under (a)(5) no later than (13) calendar days from the date the program receives a payment for the complete amount of family contributions owed by the applicant.
(e) The program shall notify applicants in writing of the effective date of coverage for all persons determined to be eligible.

(f) During the AIM-linked infant's eligibility determination, the infant's effective date of coverage will occur for any months in which the infant qualifies for the HFP. The HFP Regulations were revised to identify that the eligible infant's start date of coverage with the HFP occur on the following days:

- On the infant's date of birth, so long as the child is not enrolled in the No-Cost Medi-Cal Program on their birth date or enrolled in ESI on their birth date; and

- After the infant's date of birth, when the infant's No-Cost Medi-Cal or ESI coverage ends.

  Here are a few examples to describe how the effective date of coverage will be established:

Scenario #1 (Infant doesn't have No-Cost Medi-Cal or ESI coverage):

The mother registers the infant after the 1st month of birth. The child is born on July 1, 2007. The infant registration form indicates that the child is not currently and was not previously enrolled in ESI. After the MEDS File Clearance process, the HFP determines that the child is not enrolled in the No-Cost Medi-Cal Program. The HFP enrolls the infant into the program, establishing an effective date of coverage on July 1, 2007.

- The Annual Eligibility Review (AER) anniversary date is July 1, 2008.
- 0C Aid Code is used through the 2nd year of life.♣
- AER eligibility determination will be based on 300% FPL providing the child is still enrolled in HFP at the 1st year AER.
- AER eligibility determination will be based on 250% FPL providing the child is still enrolled in HFP at the 2nd year.

Scenario #2 (Infant previously had No-Cost Medi-Cal):

The mother registers the infant after the 5th month of birth. The child is born on August 10, 2007. The infant registration form indicates that the child is not currently enrolled and was not previously enrolled in ESI. After the MEDS File Clearance process, the HFP determines that the child is enrolled in the No-Cost Medi-Cal Program from August 10, 2007 through October 31, 2007. The HFP enrolls the infant into the program, establishing an effective date of coverage on November 1, 2007 through August 31, 2008.

- The AER anniversary date is August 10, 2008.
- 0C Aid Code used through the 2nd year of life. ♣
- AER eligibility determination will be based on 300% FPL providing the child is still enrolled in HFP at the 1st year AER.
- AER eligibility determination at will be based on 250% FPL providing the child is still enrolled in HFP the 2nd year.

Scenario #3 (Infant previously had ESI):

The mother registers the infant after the 6th month of birth. The child is born on July 1, 2007. The infant registration form indicates that the child is not currently enrolled in ESI. However, the applicant specifies that the child was previously enrolled in ESI coverage. ESI coverage began on July 1, 2007 and ended November 30, 2007 because of a change in job status. After the MEDS File Clearance process, the HFP

♣ 0C Aid Code will be used for 2nd year if child has continuous enrollment during 1st year AER.

determines that the child is not currently and was not previously enrolled in the No-Cost Medi-Cal Program. Since the ESI coverage ended due to an exception circumstance where the infant is not subject to the 3-month waiting period, the HFP enrolls the infant into the program, establishing an effective date of coverage on December 1, 2007 through July 31, 2008.

- The AER anniversary date is July 1, 2008.
- 0C Aid Code used through the 2nd year of life.♣
- AER eligibility determination will be based on 300% FPL providing the child is still enrolled in HFP at the 1st year AER.
- AER eligibility determination at will be based on 250% FPL providing the child is still enrolled in HFP the 2nd year.

Scenario #4 (Infant previously had No-Cost Medi-Cal and ESI):

The mother registers the infant after the 9th month of birth. The child is born on August 31, 2007. The infant registration form indicates that the child is not currently enrolled in ESI. However, the applicant identifies that the infant was previously enrolled in ESI during February 1, 2008 through March 31, 2008. The ESI coverage ended because of a legal separation/divorce. ESI coverage ended due to an exception circumstance where the infant is not subject to the 3-month waiting period. After the MEDS File Clearance process, the HFP determines that the child is not currently enrolled in the No-Cost Medi-Cal Program. MEDS indicates that the child previously had No-Cost Medi-Cal coverage during August 31, 2007 through October 31, 2007. The HFP enrolls the infant into the program, establishing effective dates for days and months in which the child does not have No-Cost Medi-Cal or ESI coverage. In this scenario, the infant has 2 separate effective date periods, which occur on November 1, 2007 through January 31, 2008 and April 1, 2008 through August 31, 2008.

- The AER anniversary date is August 31, 2008.
- 0C Aid code used through the 2nd year of life.♣
- AER eligibility determination will be based on 300% FPL providing the child is still enrolled in HFP at 1st year AER.
- AER eligibility determination at will be based on 250% FPL providing the child is still enrolled in HFP the 2nd year.

Scenario #5 (Infant previously had ESI and is subject to 3-month waiting period):

The mother registers the infant after the 5th month of birth. The child is born on November 23, 2007. The infant registration form indicates that the child is not currently enrolled in ESI. However, the applicant identifies that the infant was previously enrolled in ESI during January 1, 2008 through March 31, 2008. The ESI coverage ended because the applicant could not afford the premiums. The infant is

♣ 0C Aid Code will be used for 2nd year if child has continuous enrollment during 1st year AER.

subject to the 3-month waiting period because the reason that the ESI coverage ended does not fall within an exception that is identified in the HFP Business Rules. After the MEDS File Clearance process, the HFP determines that the child is not currently and was not previously enrolled in the No-Cost Medi-Cal Program. The HFP enrolls the infant into the program, excluding months and days in which the child has ESI coverage and the 3-month waiting period. The 3-month waiting period ends on June 30, 2008. In this scenario, the infant has 2 separate effective date periods, which occur on November 23, 2007 through December 31, 2007 and July 1, 2008 through November 30, 2008.

- The AER anniversary date is November 23, 2008.
- 0C Aid code used through the 2nd year of life.♣
- AER eligibility determination will be based on 300% FPL providing the child is still enrolled in HFP at 1st year AER.
- AER eligibility determination at will be based on 250% FPL providing the child is still enrolled in HFP the 2nd year.

Scenario #6 (Infant previously had ESI and is subject to 3-month waiting period):

The mother registers the infant after the 10th month of birth. The child is born on October 1, 2007. The infant registration form indicates that the child is not currently enrolled in ESI. However, the applicant identifies that the infant was previously enrolled in ESI during October 1, 2007 through August 15, 2008. The ESI coverage ended because the applicant requested to terminate coverage. The infant is subject to the 3-month waiting period because the reason that the ESI coverage ended does not fall within an exception that is identified in the HFP Business Rules. After the MEDS File Clearance process, the HFP determines that the child is not currently and was not previously enrolled in the No-Cost Medi-Cal Program. The 3-month waiting period ends on November 15, 2008. The child is not eligible for the HFP as an AIM-linked infant because the 3-month waiting period ends after the child turns 1 year old. In this scenario, because the infant does not have HFP coverage ending on the last month of the infant turning 1, there is no AER date. Since the application is received four months prior to potential eligibility, the applicant would need to reapply if HFP enrollment is still desired. In the event the applicant later re-applies for the child, the HFP will base the eligibility determination on the HFP income guidelines (up to 250% of the FPL).

- 9H Aid code would be used, if child later enrolled into HFP.

Scenario #7 (Infant previously had ESI and currently enrolled in No-Cost Medi-Cal):

7a. The mother registers the infant after the 9th month of birth. The child is born on September 15, 2007. The infant registration form indicates that the child is not

♣ 0C Aid Code will be used for 2nd year if child has continuous enrollment during 1st year AER.

currently enrolled in ESI. However, the applicant identifies that the infant was previously enrolled in ESI during the period of December 1, 2007 through March 15, 2008. ESI coverage ended because the employer ended benefits to all employees. After the MEDS File Clearance process, the HFP determines that the child is currently enrolled in the No-Cost Medi-Cal Program and has been enrolled since June 1, 2008 with no termination date for Medi-Cal on MEDS. On June 20, 2008, the HFP completes the eligibility determination and enrolls the infant into the program, establishing effective dates for days and months in which the child does not have No-Cost Medi-Cal or ESI coverage. In this scenario, infant has two separate effective date periods, which start on September 15, 2007 and ended November 30, 2007. Then, since the ESI coverage ended due to a circumstance where the infant is not subject to the 3-month waiting period, the HFP enrolls the infant for the second uninsured period, establishing an effective date of coverage on March 16, 2008 through May 31, 2008. The infant is denied HFP coverage for the period of June 1, 2008 through September 31, 2008 because the child currently has No-Cost Medi-Cal coverage.

- The AER anniversary date is September 15, 2008.

7b. During the 10th month following birth, the HFP later receives a request from the applicant to enroll the infant. The child is not currently enrolled in ESI. After the MEDS File Clearance process, the HFP determines that the infant's No-Cost Medi-Cal coverage ends on July 31, 2008. Because the information to enroll the child is received within the 11 months following birth, the child qualifies for the HFP as an AIM-linked infant. The HFP re-enrolls the child into the program establishing another new effective date of coverage beginning on August 1, 2008 through September 31, 2008. In this scenario, the child has an additional separate enrollment period with the HFP.

- The AER anniversary date is September 15, 2008.
- 0C Aid code used through the 2nd year of life.♣
- AER eligibility determination will be based on 300% FPL providing the child is still enrolled in HFP at 1st year AER.
- AER eligibility determination at the 2nd year will be based on 250% FPL providing the child is still enrolled in HFP.

Scenario #8 (Infant Enrolled in 2nd Month of Life due to ESI in 1st month of life):

Mother registers the infant after the 1st month of birth. The child is born July 2, 2007. The registration form indicates the child had ESI for the month of birth. ESI ended due to loss of a job. ESI coverage ended due to an exception circumstance where the infant is not subject to the 3-month waiting period. After the MEDS File Clearance process, the HFP determines that the child is not currently, nor has been, enrolled in the No-Cost Medi-Cal Program. The HFP enrolls the infant into the program with an effective date of August 1, 2007.

♣ 0C Aid Code will be used for 2nd year if child has continuous enrollment during 1st year AER.

- The AER anniversary date is July 2, 2008.
- 0C Aid code used through the 2nd year of life.♣
- AER eligibility determination will be based on 300% FPL providing the child is still enrolled in HFP at 1st year AER.
- AER eligibility determination at the 2nd year will be based on 250% FPL providing the child is still enrolled in HFP.

9. Eligible Qualified Immigrants:

Refer to the HFP handbook for acceptable provisions of immigration statuses.
The following is a list of qualified immigrant statuses

1) Alien lawfully admitted for permanent residence;
2) Alien granted conditional entry;
3) Alien paroled into U.S.;
4) Alien with appropriate immigration status who (or whose child or parent) has been battered or subject to extreme cruelty in the U.S. under the Victims of the Violence Against Women Act;
5) Alien granted asylum
6) Refugee admitted to the U.S.;
7) Alien whose deportation is being withheld by order of an immigration judge;
8) Alien who is a Cuban or Haitian entrant;
9) Alien lawfully residing who are honorably discharged veterans or active duty military;
10) Spouse or Dependent of veteran/active duty military; and
11) Amerasian immigrant admitted to the U.S.

Initial Application verification of Immigration Documentation

- A Date of Entry on acceptable immigration documentation provided does not affect a child's eligibility for the HFP.
- A Date of Entry must be captured and stored if provided during processing of an application.
- If an expiration date is identified on an immigration document, the date cannot be expired. If the document is expired, it is considered to be unacceptable.
- If the child's immigration documentation is acceptable and does not have a field for the expiration date, the HFP will process that documentation as an acceptable and as an un-expired document.
- If the child's immigration documentation is acceptable and had a field for expiration date, but no expiration date has been identified (i.e. the expiration date is blank), the HFP will process that documentation as an acceptable and as an un-expired document.

- If the immigration documentation is missing, not acceptable or is already expired, this is considered critical missing information.
- If the immigration documentation is not received within the first two (2) months of enrollment, the child will be disenrolled at the end of the second month of enrollment. The child will be eligible for Continued Enrollment (CE).
- A child is granted twelve (12) continuous months of HFP coverage, as long as at the time of making an initial application eligibility determination, or within the first two months of enrollment, the immigration documentation provided to the HFP is acceptable and is not expired. For example:
  - An eligibility determination is made on August 15, 2009;
  - The child's acceptable immigration document identifies that the expiration date is August 16, 2009;
  - The child will be eligible for the HFP for one year, since on August 15, 2009 the document provided to the HFP was valid.
- If the child is disenrolled as a result of not providing acceptable immigration documentation, the applicant will also need to submit acceptable and un-expired immigration documentation at the time of re-applying.

10. Referrals to AB 495 and Healthy Kids Participating Programs:

Upon implementation, referral information will be provided to applicants with children determined income too high at initial application and Annual Eligibility Review (AER) determinations. The referral information will include contact information for the CHI program in which the child resides.

An applicant may use the contact information to send their child's application to one of the following county/health plan partnerships if the child is determined over income:

- Santa Clara
- San Mateo
- San Francisco
- Alameda

At AER, the disenrollment letter (for income above HFP guidelines) shall be modified to include information about the AB 495 project referral. Note: Referral to the AB 495 projects may also occur for applications received via Health-e-App or the paper application. A process similar to the referral process to the county Medi-Cal offices (for income below the HFP guidelines) must be established at the HFP for the AB 495 project for those eligibility determinations where the income is above the HFP guidelines. For example, the current list of Medi-Cal/county addresses used to forward below HFP income applications can be

modified to incorporate AB 495 project addresses used to forward over HFP income applications. In the event the HFP conducts an eligibility determination (i.e. during initial application, re-enrollment process, or AER process) and concludes that the child does not qualify for the HFP as a result of the income being above the HFP guidelines and the child resides in an AB 495 county, the HFP shall inform and refer the applicant to the AB 495 project in the denial letter. It is anticipated that more county projects will become operational.

11. Initial Enrollment on or after November 1, 2009:

- A Family will be allowed to enroll into any dental plan that is available in their county/zip code of residence at the time of enrollment, unless the following occurs:

    - Families did not have <u>any</u> child enrolled in the HFP for 24 consecutive months. The family will have limited dental plan choices if they reside in a county/zip code that has a limited dental plan available. Limited dental plans are other dental plans, which are <u>not</u> Delta Dental or Premier Access. If the county/zip code does not have a limited dental plan available, then the family will be allowed to enroll in any dental plan (including Delta Dental or Premier Access) that is available to them. Refer to the Limited Dental Plan Choices section of the HFP Business Rules.
    - 24 consecutive months means that any child was continuously enrolled in the program during this period without a break in coverage.
    - Families enrolled into Special Population Plan are not subject to limited dental plan choice rules.
    - Families that reside in a county/zip code area that only has Delta Dental or Premier Access as available dental plans can select these plans. Refer to the Limited Dental Plan Choices section of the HFP Business Rules.
    - Families that do not provide their plans or provides incorrect plans, the application will be sent to call back and HF Letter 005 will be sent to the applicant to request for the missing information. Refer to the Alternate Plan Assignment section of the HFP Business Rules.
    - Families that do not have (or previously had) <u>any</u> child enrolled for 24 consecutive months of HFP coverage and the family does not provide a dental plan or provides an invalid selection, the auto plan assignment process will automatically assign any limited dental plan that is available to them, in the county/zip code of residence. Refer to the Limited Dental Plan Choices section of the HFP Business Rules.

12. Continued Enrollment:

An applicant may request Continued Enrollment (CE) in the HFP while a first level appeal is being determined. CE will continue until the first level appeal has been adjudicated. Premiums and co-pays are required during the continued enrollment period. However, lack of payment does not constitute a CE denial.

- HFP will notify applicants of a potential disenrollment and provide the CE form and instructions no less than 15 calendar days prior to the date of disenrollment.

An applicant may request CE by completing the CE form or by writing to the HFP. (A CE form without a signature and at least one of questions 1 - 4 answered will be accepted). The CE request must be received by the disenrollment date.

HFP will process CE forms received prior to 8:00pm (which will indicate the date of receipt) on the same business day. Notices of whether CE was granted or denied will be sent to the applicant within 3 business days.

CE will be granted for all family members when there are multiple disenrollment reasons but only one CE request is submitted. When an appeal requesting CE is received for an individual decision (i.e., income too low) and there is a family level disenrollment (i.e., non-payment) set for the same date, all enrolled members remain enrolled until the appeal is adjudicated.

Term Code	Description	CE Available
607	Valid citizenship/immigration docs not received	Yes
0802	Subscriber reached 19 years of age	Yes
0804	Subscriber is deceased	No
800	Erroneously Enrolled	No
0806	Premium two months overdue	Yes
0808	Applicant requested termination	No
0809	False Declarations	Yes
0811	AER, currently in No-Cost Medi-Cal	Yes
0812	AER, Medicare A&B eligible	Yes
0813	AER, No-Cost Medi-Cal/Burman Lawsuit	Yes
0814	AER, No-Cost Medi-Cal under SSI/SSP, DSS	Yes
0819	AER information not received	Yes
0821	AER, income qualifies for No-Cost Medi-Cal	Yes
0822	AER, income exceeds HFP limits	Yes

0823	AER, covered by employer sponsored insurance	Yes
0824	Additional AER documents requested not received	Yes
0826	Subscriber disenrolled by request during AER	No
0841	Child no longer living in household	Yes
0844	Applicant request because subscriber out of state	No
0845	Subscriber out of State at AER	Yes

13. Disenrollment From The Healthy Families Program

An applicant will receive at least a 15-day written notice before disenrollment from the program. This notice shall also contain appeal rights, CE form (except for disenrollment by request or death of subscriber, see sections on CE for listing) and date of pending disenrollment. If any of the following occurs, Healthy Families coverage will end and the person will be disenrolled from the Healthy Families Program:

- Healthy Families finds that the household income is above Healthy Families income guidelines during the Annual Eligibility Review. Disenrollment will occur at the end of the subscriber's anniversary month, unless CE has been granted, in which case disenrollment will occur at the end of the following month if no qualifying information is provided. Reason code: 0822 – Income too high.

  Healthy Families finds that the household income is below Healthy Families income guidelines during the Annual Eligibility Review. Disenrollment will occur at the end of the subscriber's anniversary month, unless CE has been granted, in which case disenrollment will occur at the end of the following month if no qualifying information is provided. The subscriber will be forwarded to their respective County Department of Social Services for a Medi-Cal determination and if the child qualifies will receive no-cost Medi-Cal Presumptive Eligibility. Reason code: 0821 – Medi-Cal eligible.
- The required AER documentation is not provided prior to the end of the subscriber's anniversary month, unless CE has been granted. Disenrollment will be effective at the end of the month of the subscriber's anniversary date. Reason code: 0819 –AER information was not received.

- Healthy Families finds that a subscriber during the Annual Eligibility Review is currently enrolled in no-cost Medi-Cal with no termination date posted in MEDS. Disenrollment will occur at the end of the subscriber's anniversary month, unless CE has been granted, in which case disenrollment will occur at the end of the following month if no Notice of Action is provided. Reason code: 0811, 0812, 0813, 0814 – No-Cost Medi-Cal active.

- The AER packet indicates the subscriber has been enrolled in Employer Sponsored Insurance within the last 90 calendar days and coverage did not end due to change in employment, moved, employer ended all benefits to all employees, death of the individual that provided coverage, or COBRA ending. Disenrollment will be effective at the end of the month of the subscriber's anniversary date, unless CE has been granted, in which case disenrollment will occur at the end of the following month. Reason code – 0823 – AER, covered by employer sponsored insurance.

- Additional required documentation requested during the AER process is not provided. If CE was sent specifically for additional information requested and not received within 15 days prior to the end of the anniversary date, then disenrollment will be effective at the end of the month of the subscriber's anniversary date, unless CE has been granted, in which case disenrollment will occur at the end of the following month if required documentation is not received. Reason code: 0824 – Additional AER documentation requested was not received.

- The child reaches 19 years of age. Disenrollment will be effective on the last day of the month the subscriber child turns 19, unless CE has been granted, in which case disenrollment will occur at the end of the following month if no correcting documentation has been received. Reason code: 0802 – subscriber reached 19 years of age.

- The subscriber's premium is **not** paid for two (2) months after the due date. Disenrollment will be effective the last day of the 2nd month of non-payment, unless CE has been granted, in which case disenrollment will occur at the end of the following month if payment has not been received. Reason code: 0806 – Non-payment of Premium

- The applicant writes to Healthy Families requesting to end the enrollment. Disenrollment will be effective at the end of the month in which the applicant's request was received, or at the end of the month the applicant requests disenrollment to be effective, if in the future. No CE notice will be sent. Reason codes: 0826 – disenrollment at AER per applicant's request. 0808 – Applicant request.

- Healthy Families finds that the applicant has made false declarations concerning the child's eligibility. Disenrollment will be effective at the end of the month in which the determination was made unless CE has been granted, in which case disenrollment will occur at the end of the following month if no correcting documentation has been received. In cases where there is a question of current Employer Sponsored Insurance and/or HFP enrollment, the program shall forward the information to the MRMIB for review. Generally, MRMIB will direct HFP of these disenrollments. Reason code: 0809 – False declarations.

- The subscriber does not provide the birth certificates, or acceptable and un-expired INS documents within two (2) months from the enrollment date. Disenrollment will be effective at the end of the 2nd full month of enrollment unless CE has been granted, in which case disenrollment will occur at the end of the following month if acceptable and un-expired immigration documentation has not been received. For example, a child is determined eligible and enrolled in the HFP on January 15th; disenrollment effective date shall be March 31st. If the subscriber subsequently submits a re-enrollment form or a new application, acceptable birth certificate or acceptable and un-expired INS documentation must be received prior to enrolling the child previous disenrollment for these reasons with the re-enrollment form or new application.

  Reason codes:
  - 0607 – Valid Citizenship/Immigration Documentation not received.
  - 0606 – Proof of citizenship missing or invalid.

- Death of subscriber. Disenrollment will be effective at the end of the month in which death occurred. If the notification is received after the month of death, HFP must retroactively disenroll and make the appropriate adjustments to the capitation payment and premium payments. No CE will be sent. Reason code: 0804 – subscriber is deceased.

- If the applicant notifies the program that the subscriber has moved out of state and is no longer a resident of California and requests disenrollment, disenrollment will occur at the end of the month the request was received or at the end of the month the applicant requests disenrollment to be effective, if in the future. No CE notice will be sent. Reason codes: 0844 – Subscriber out of state, applicant request.

- If the applicant notifies the program of a change in address and the new address is out of state but does not request disenrollment, then disenrollment will be effective at the end of the month of the subscriber's anniversary date, unless CE has been granted, in which case disenrollment will occur at the end of the following month. Reason code: 845 – Subscriber out of state at AER.

In some cases it will be necessary to have both a primary and a secondary disenrollment/ineligible code. In addition, the CE notices should also have the capability to notify the applicant of two different disenrollment reasons.
For avoidable disenrollment reasons (e.g., false declaration, non-payment, etc.), the subscriber will receive at least a 15 calendar day written CE notice before a child's health, dental, and vision coverage ends, and is disenrolled from the program. The notice shall also contain appeal rights and Continued Enrollment Form (except for death of subscriber or disenrollment by request) and date of pending disenrollment. If the CE notice does not allow the applicant 15 days to respond, the pending disenrollment will be the last day of the following month, in order to give the applicant sufficient time to respond to the disenrollment decision.

When a person is disenrolled for nonpayment of the premium and requests re-enrollment, any past due premiums for the last 12 months (from the date of the re-enrollment request) shall be paid in full before re-enrollment may occur.

14. Re-Enrollment:

- An applicant may use the HFP Re-enrollment Form (HF FM 58) or the application to be considered for re-enrollment. Re-enrollment forms are to be sent to the applicant along with the appropriate disenrollment letter.

- The Re-enrollment form will only be accepted if it is received within 60 days from the HFP disenrollment date. Any Re-enrollment forms received after the 60th day from the date of disenrollment (using the pre-printed "expiration date" on the Re-enrollment form) should not be processed and are not subject to appeal rights. The HFP will send the appropriate letter to the applicant explaining the reason for the denial and that they must re-apply.

- New HFP Applications, including those received within 60 days from the disenrollment date of the HFP, will be processed under the normal "new application" processing rules. This process includes the applicant designating their plan(s) selection.

- Re-enrollment forms will be sent to the appropriate program using the new income verification provided by the applicant or the stated income amount(s) and frequency of receipt listed on the Re-Enrollment form.

- Re-enrollment forms for children forwarded to the Medi-Cal Program will be sent to the County with a copy of the **most recent** application (i.e., AER package, Application) and all documentation received with the re-enrollment form and/or obtained through callbacks. A child forwarded to Medi-Cal as a result of a Re-enrollment form will be granted accelerated enrollment (AE), if eligible for AE.

- Re-enrollment forms and applications received from applicants whose children were disenrolled from the HFP due to missing, un-acceptable or expired Immigration or Citizenship documents received after two (2) months, must submit the required form(s) (i.e. birth certificate or acceptable and un-expired immigration documents) with the re-enrollment form (or new HFP Application). These immigration documents **must** be acceptable and un-expired or the re-enrollment will be denied. The HFP will use the appropriate letter to notify the applicant of this type of denial.

- Re-Enrollment forms and applications must include payments for any outstanding HFP premiums owed (if any).

- The Welcome Letter will be sent to applicants whose children have been determined eligible for re-enrollment in the HFP and will include the effective date of coverage for each subscriber(s).

- The Re-enrollment will result in all eligible children being re-enrolled into the same plans they were in prior to disenrollment, unless those plans have reached the enrollment cap or no longer serve their area (due to Open Enrollment (OE), the plan contract ended, and not open to new enrollment). If the prior plan does not serve their area (or the family has a new address that results in the need for new plan selections), the applicant will be contacted through the established processes and informed that a new selection(s) must be submitted in writing or by phone, by the applicant. If the applicant has not submitted a plan selection by the due date and plan choices are the only missing information, this situation will result in the subscriber being auto assigned into a plan in the area in which they reside in. (Refer to Alternate Plan Assignment and Limited Dental Plan sections of the HFP Business Rules.)

- A child enrolled in the HFP as a result of a Re-enrollment will be allowed to transfer to a new plan within the first three (3) months from the new re-enrollment effective date, as do any other new enrollees. This information is currently included on the Welcome Letter. (Refer to Transfers and Limited Dental Plan sections of the HFP Business Rules.)

- The HFP will check the Medi-Cal Eligibility Data System (MEDS) for all HFP eligible children via file clearance process, to verify if they are not currently enrolled in no-cost Medi-Cal, prior to re-enrolling them in the HFP. Children can be enrolled in HFP when Medi-Cal coverage is Presumptive Eligibility or Shared Cost of Service. Missing information will be assessed in the same manner and time frames as the applications, with the exception of those elements not requested on the Re-enrollment form (e.g., plan selection). The HFP will attempt the appropriate telephone call and send out the appropriate Missing Information letter to the applicant in order to obtain the required missing information.

- Re-enrollment effective dates are subject to the same methods of calculation as all other effective dates.

- The HFP will send the appropriate notification to the plans as a result of a re-enrollment.

15. Appeals:

Note: A method to track appeals received by the vendor and their status should be developed and accessible by the state.

An applicant may file an appeal if s/he believes eligibility effective date of coverage, enrollment decision, or disenrollment decision was made in violation of the program rules. An applicant may designate an authorized representative to file the appeal and inquire about the status of the appeal.

The applicant must file a written appeal within 60 calendar days from the date of the written notice of the decision. The Healthy Families Program will respond to the appeal in writing within 15 business days of receipt.

If an appeal is incomplete or does not concern at least one of the three issues listed above or is received beyond the specified timeframe (i.e., 60 days), the applicant is not entitled to a full appeal and the administrative vendor will review the request and process as correspondence.

The Healthy Families Program has a three-step appeals process. These steps are referred to as:

- First Level Administrative Reviews
- Second Level Administrative Reviews
- Administrative Hearings

A. **First Level Appeal:**

First level appeals are written appeals received by the HFP Administrative Vendor or MRMIB for the first time. A first level appeal must be filed within **60 days** of the date on the decision notification by vendor or state. The administrative vendor will process first level appeals within 15 business days of receipt. The appeal must explain why the applicant thinks the decision was incorrect and how they want the program to resolve the issue. An appeal form is sent with the disenrollment notice.

If a first level appeal is denied, the applicant will be notified of his or her right to request a second level appeal review with the Executive Director of MRMIB.

B. **Second Level Appeal:**

Second level appeals are timely appeals from first level appeal decisions made by the HFP Administrative Vendor or MRMIB. A second level appeal must be filed within 30 days of the first level appeal decision notification. All second level appeals will be processed by MRMIB. A copy of the MRMIB response letter to the applicant will be forwarded to the administrative vendor. The administrative vendor will scan the document into the case file.

If a second level appeal is denied, the applicant will be notified by MRMIB of his or her right to request a State administrative hearing.

If a 2nd level appeal is received by the vendor, it will be forwarded to MRMIB within 5 business days of receipt.

C. **Administrative Hearing:**

An applicant may request an administrative hearing only if he or she has complied with both the first and second level appeal processes. An Administrative Law Judge (ALJ) conducts the administrative hearing and prepares a proposed decision to the Board. Decisions adopted by the Board are final and the applicant will have fully exhausted his or her appeal rights.

D. **Correspondence/Program Review:**

Correspondence includes requests that the HFP Administrative Vendor or MRMIB reviews although they do not meet at least one of the three appeal criteria or are not received by HFP or MRMIB within the specified time requirements (i.e., 60 days for first level and 30 days for second level). These reviews will be processed by HFP administrative vendor within 15 business days of receipt. If a request is denied, the applicant will be notified in writing of the decision, and will be notified that there are no further appeal rights.

16. Updating Applicant and Subscriber Information:

The adult family members, living with a HFP subscriber, who are authorized to provide subscriber information and update subscriber information, include:

- The applicant,
- The applicant's spouse, and
- The parent who has a common child with the applicant.

In all cases, the adult providing the information or requesting to update the information must be living in the household and must have been listed on the most recent HFP application or AER. The most recent application, including the

AER form and Add A Person form, will be used by the HFP to verify that the requestor is a family member who is currently living in the household.
Examples of information that may be updated or changed include but are not limited to: changes of address, household composition changes, and income changes (i.e., premium re-evaluation). Any family member who meets the above criteria is also authorized to sign various forms required by the HFP (e.g., AER form, Program Review form, Continuous Enrollment form, Add a Person form).

Updating residence and mailing addresses: Residence addresses may be updated at any time if received in writing by the applicant, spouse, or other parent living in the home, who has a child enrolled in the program, and who is listed on the last application received. The residence address may also be updated at any time by phone if the **applicant** is providing the change of address and there would be no plan change. The residence address may **only** be within the State of California (if address change is outside of California, this will result in a loss of residence disenrollment). If the change of address requires a change of plan, HFP will send a letter requiring a new plan selection and require that the selection be made in writing. The same rules are to be followed for updating phone numbers.

17. Presumptive Eligibility

Presumptive Eligibility (PE) is immediate, temporary, fee-for-service, full-scope, no-cost Medi-Cal coverage. California Department of Health Care Services (DHCS) will establish aid code 5E for PE. Until aid code 5E is available, aid code 8E used for Accelerated Eligibility (AE) will also be used for PE. PE will not be granted to subscribers who currently have Medi-Cal coverage in the current or pending month. Subscribers may qualify for PE if the family's household income is below HFP guidelines at AER or have requested Medi-Cal using a Premium Re-evaluation.

A. PE at Annual Eligibility Review:

- If HFP determines the subscriber is no longer eligible for the program during AER because his or her household income is below the program guidelines, HFP must inform subscribers of the potential disenrollment including Continued Enrollment (CE) rights and them possibly being eligibility for PE.

- If HFP determines the subscriber is no longer eligible for the program during AER because his or her household income is below the program guidelines, the application shall be forwarded to the applicant's local County Department of Social Services, as determined by the applicant's zip code.

- If a child qualifies for PE, coverage for PE is effective the first day of the month following their disenrollment from HFP.

- Transactions to MEDS for PE will occur at the end of the disenrollment month that HFP determines the subscriber is no longer eligible for the program because the subscriber's household income is below the program guidelines.

- If HFP determined the subscriber is no longer eligible for the program during AER because his or her household income is below the program guidelines, and prior to disenrollment, the program receives information to determine the subscriber is now eligible for HFP, then coverage in HFP will be reinstated and the subscriber will not be eligible Presumptive Eligibility. No transactions will be sent to MEDS for PE.

B. PE at Premium Re-evaluation:

- If HFP determines the subscriber is no longer eligible for the program during Premium Re-evaluation because his or her household income is below the program guidelines, disenrollment will be effective at the end of the determination month and PE may be granted. If a child qualifies for PE, coverage for PE is effective the first day of the month following their disenrollment from HFP.

  1. The application shall be forwarded to the applicant's local County Department of Social Services, as determined by the applicant's zip code.
  2. Transactions will be sent to MEDS at the end of the month that the subscriber is disenrolled from HFP.

- If HFP determines the subscriber is no longer eligible for the program during Premium Re-evaluation because his or her household income is below the program guidelines, the subscriber will continue enrollment in HFP and PE will not be granted. The premium will be lowered to the lowest monthly premium amount.

18. American Indian and Alaska Native Waiver

- If an applicant or the person for whom the application is being made is American Indian or Alaska Native (declared on application as ethnicity code 5A/5B), the person may be exempt from family contribution payments and benefit co-payments.

- The parents and siblings living the household of the person, who is American Indian or Alaska Native, may be exempt from family contribution payments and benefit co-payments if the person is eligible for HFP.

- The exemption of family contributions payments and benefit co-payments shall occur after receipt of one of the following required and acceptable documentation:
    1. An American Indian or Alaska Native enrollment document from a federally recognized tribe.
    2. A Certificate Degree of Indian Blood (CDIB) from the Bureau of Indian Affairs.
    3. A Certificate of Indian Heritage from an Indian Health and Service supported facility operating in the State of California.

- If the applicant or the person who is an American Indian or Alaska Native is unable to provide any of the above documents at the time of the application, the exemption from family contribution will begin on the date of enrollment and continue for two (2) months pending the receipt of acceptable documentation. The co-payments are not waived during this time period.

- If acceptable documentation is not received at the end of the two-month exemption period, the appropriate premium will be assessed beginning the first day of the first full month following the end of the second month of enrollment during which the applicant has not provided acceptable documentation.

19. Add A Person Application – Existing member(s) enrolled (Open Case):

- The first day of coverage begins 10 calendar days from the date the HFP determines that the person qualifies for the Program and resets all existing members anniversary date for purposes of annual eligibility review.

- If the application is incomplete, HFP will try to reach the applicant by phone. The applicant will be notified in writing within 2 business days of determining that the application is incomplete.

- If the person does not qualify for HFP because the income in the person's household is below the HFP guidelines, the Add a Person application and the last application (initial or AER) will be forwarded to the County Department of Social Services that same day the eligibility determination is made. The County will process the application in approximately 45 days.

- If the person does not qualify for HFP because the income in the person's household is below the HFP guidelines, the person will receive accelerated enrollment to Medi-Cal.

- The person will be enrolled into the same plans the existing members are already enrolled in.

20. Add A Person Application – Existing member(s) disenrolled (Closed Case – within 60 days from disenrollment date)

- Add a Person Application will be treated as a New Application. The persons listed on the Add a Person are being applied for; all other disenrolled members will be considered as other members living at home if the Add a Person form is received within 60 days from the disenrollment date (the date case closed).

- If the case has been disenrolled for more than 60 days, pre-printed letter 45 will be sent to the applicant for more information.

- Applicant information including name, addresses, contact numbers and languages will be used from the previous most recent complete application on file if the Add a Person form is received within 60 days from the disenrollment date.

- Applicant's first name is changed, for example from Robert to Bob or the last name is changed from Smith to Jones. Change the applicant's name without requiring proof, if:

    - Applicant is changing name to carry spouse's last name
    - Applicant is using short name instead of full name like Bob for Robert.
    - If the name is completely changed to where it could be a different person, proof of name change will be required.

- Family size (any other members living in the home), AI/AN and seasonal worker information will also be used from the previous most recent complete application on file if the Add a Person form is received within 60 days from the disenrollment date.

- The first day of coverage begins ten (10) calendar days from the date the HFP determines that the person qualifies for the Program.

- If the application is incomplete HFP will try to reach the applicant by phone. The applicant will be notified in writing within two (2) business days of determining that the application is incomplete.

- If the person does not qualify for HFP because the income in the person's household is below the HFP guidelines the Add a Person application and the last application (initial or AER) will be forwarded to the County Department of Social Services.

- If the person does not qualify for HFP because the income in the person's household is below the HFP guidelines, the person will receive accelerated enrollment to Medi-Cal, if eligible.

- The person will be enrolled into the same plans the existing members were enrolled in at the time of disenrollment.

    - If the same plans are not available and the applicant did not choose a new plan, HFP will try to reach the applicant by phone. The applicant will be notified in writing within two (2) business days of determining that the application is incomplete.
    - If applicant does not choose a plan within 20 days from the date Add a Person form is received, HFP will alternately assign plans.

21. Annual Eligibility Review (AER):

Each year, the applicant will be asked to confirm the subscriber's qualifications for the HFP. In order to requalify for the HFP during the AER process, the child must meet all the eligibility requirements as listed in sub-section one (1) of the Business Rules titled: "*Eligibility Requirements For Children*".

The applicant will be notified by mail of the AER process at least 60 calendar days prior to the subscriber's anniversary date in the HFP. "Anniversary date" is defined as the day each year that corresponds to the day and month a subscriber's coverage began in the program. AER forms are due by the last day of the anniversary. For example, if a subscriber's effective date of coverage began on March 1, 2004, then, the subscriber's anniversary date is March 1, 2005, and the AER is due by March 31, 2005.

- Instructions to the applicant state that HFP must receive the AER form at least 10 calendar days before the end of the anniversary month. However, HFP shall process an AER form up through the last day of the anniversary month in order to prevent a disenrollment.

- If the subscriber continues to qualify for the HFP during the AER process, coverage will continue for one additional year from the anniversary date, (i.e. the original anniversary date does not change).

- In the event the HFP receives an AER packet for an HFP enrolled subscriber who is subsequently identified as being pregnant during the AER process, the HFP will count the unborn child as a family member. When determining the pregnant teen's income, the HFP will only use the child's own separate income and/or the teen spouse's income (if residing in the home) and forward to Medi-Cal if income is too low for HFP.

- The subscriber will be disenrolled at the end of the anniversary month if:
    - The subscriber is enrolled in a no-cost Medi-Cal program during MEDS File Clearance;
    - The subscriber is currently enrolled in an Employer Sponsored Insurance;

- The subscriber is no longer a resident of the state;
- The subscriber's household income is above or below the program's income guidelines during the AER process;
- The subscriber is no longer a qualified legal immigrant; or
- The subscriber does not provide the required AER documentation.

- HFP will process a complete AER packet within 7 business days of receipt.

- If the AER packet is incomplete, HFP will attempt to obtain all necessary information to determine eligibility by contacting the applicant by phone and sending a letter requesting the additional missing information.

- An applicant may designate in writing an authorized representative to inquire about the status of the AER. The permission ends once the HFP sends written notification to the applicant about the eligibility decision.

- HFP will reinstate an eligible member if the AER was received by the end of the anniversary month but not processed until after the anniversary month.

A. AER Verification For Legal Immigrant Children

- During the AER process, un-expired immigration documents are considered critical missing information. If the immigration documentation is missing, not acceptable or is already expired, this is considered critical missing information.
- Acceptable and un-expired documentation will be solicited through the AER packets, for all children with immigration documentation on file that is missing, has already expired or is going to expire on or before the first (1^{st}) of the month immediately following their anniversary month. The applicant will be notified in their AER packets to send the HFP acceptable and un-expired immigration documentation for each child that has Healthy Families coverage and who is not a US Citizen/National. For example, the following are scenarios when the AER packets will solicit information for acceptable immigration documents that are going to expire and the HFP will consider the documents to be critical MI during the AER process:
    - The anniversary month is August 2009.
    - The next year's coverage (if the child re-qualifies during AER) Begins on September 1, 2009.
    - If the existing immigration document that the HFP has on file expires on or before September 1, 2009, the AER packet will solicit acceptable and un-expired immigration documents during the AER process. This will be critical MI.
    - However, in the event the immigration document expires on or after September 2, 2009, the AER packet will not solicit acceptable and un-expired immigration documents during AER. This will not be MI.

- If the child's immigration documentation already on file, does not have a field for the expiration date, the HFP will process that documentation as acceptable and un-expired.
- If the child's immigration documentation already on file, is acceptable and has a field for expiration date but no expiration date has been identified (i.e. the expiration date is blank), the HFP will process that documentation as acceptable and un-expired.
- If acceptable and un-expired immigration documentation is not provided by the end of the child's anniversary month and the immigration documentation that the HFP has is already expired, the child will be denied an additional year of HFP coverage.
- If the child is disenrolled as a result of not providing acceptable immigration documentation, the applicant will need to submit acceptable and un-expired immigration documentation at the time of re-applying.
- The immigration documentation must be acceptable and cannot be expired on the date the additional year of HFP coverage begins. For example:
  - The anniversary month is in August 2009.
  - The next year's coverage (if the child re-qualifies during AER) begins on September 1, 2009.
  - The immigration documentation cannot be expired on or before September 1, 2009 in order for the child to continue coverage to qualify for the HFP during the AER process.
  - If the immigration documentation expires on September 2, 2009, the child qualifies for an additional year of coverage.

22. Application Signatures:

For purposes of determining an application is complete when one or more forms are received together (i.e. AER form with Add-a-Person form) and only one of the applications or forms are signed, it should be considered that the signature requirements are met for the HFP when at least one form has been signed in the appropriate signature box by the applicant. This means that both forms do not need to be signed as long as they are received in conjunction with each other and at least one of the applications or forms are signed in the appropriate applicant signature box.

Health-e-App Signatures:
Applicants and CAAs are able to provide an electronic signature through the Health-e-App process. The Health-e-App public access site provides three options for signature collection. These include:

- An electronic signature
- An electronic signature pad

- A signature page that can be printed and signed by the applicant and/or CAA

The first two signatures above are captured on the Health-e-App application summary as a typed name in the signature field. Electronic signatures reduce the times that the signature provided by the applicant or CAA does not match the applicant's name or CAAs name entered on the application. The electronic signature is the official and acceptable signature of the applicant.

23. Forwarding AER, Add-a-Person, and subsequent documentation to the County:

- **AER Packets:** When forwarding an AER packet to the county, (i.e. income too low for HFP), the detailed transmittal, complete AER packet and supporting documentation need to be sent. HFP will not need to send a copy of the original application.

- **Subsequent documentation:** When subsequent supporting documentation is received for a family whose application was previously forwarded to the county, the HFP does not need to send another copy of the previously forwarded application. The subsequent documentation should be sent with a detailed transmittal only that identifies the original date the application was forwarded to the county and the subsequent documentation received.

- **Add-a-Person:** When an Add-a-Person form is submitted with an AER packet, the AER packet, Add-a-Person form, supporting documentation and the detailed transmittal should be sent to the county. A copy of the original application does not need to be sent. However, if an Add-a-Person form is submitted during the eligibility period (non-AER), a copy of the most recent application/AER should be sent, along with the detailed transmittal and the Add-a-Person form.

24. Premium Re-evaluation:

An applicant may request a re-evaluation of premiums at any time during enrollment as a result of household income changes. The premium may be adjusted to a lower level but the children will not be disenrolled if the income falls to the Medi-Cal levels or if the income exceeds HFP guidelines.

- An applicant may request a **Premium Re-evaluation** of premiums at any time during enrollment as a result of household income changes.

- New income verification received by HFP during **Premium Re-evaluation** will be assessed in order to determine if the new income qualifies the subscriber(s) for a lower monthly premium amount.

- New income verification during Premium **Re-evaluation** will **never** result in an increase of a subscriber(s) premium amount.

- New income verification during **Premium Re-evaluation** may not result in the disenrollment of HFP subscribers, if their income is determined to be too high.

25. Special Population Plan (SPP) formerly Rural Health Demonstration Project (RHDP):

NOTE: The SPP maybe selected at initial application or open enrollment.

- The insurance plan combination which offers a health, dental and vision plan combination for American Indians or families employed in seasonal jobs in agriculture, fishing, or forestry.

- The SPP is available statewide

- The plans participating in the statewide plan combination are Blue Cross RHDP, Delta Dental and VSP. Plan combination code: C999 or D999 (codes reflect different premium amount and county of residence)

- Families don't have to change plans, even if they move around the state following seasonal jobs.

- If the person is an American Indian or Alaska Native, or a seasonal or migrant worker, the person must sign a self-declaration stating: that the person is an American Indian or Alaska Native, or is a person who has been employed (within the past 24 months), in seasonal jobs, in agriculture, fishing, or forestry.

26. Premium Calculations:

To compute premium calculations (i.e., category A/category B/category C), the income of all MFBU members is to be used as long as that income was used to determine the HF eligibility of at least one MBU. If the applicant is applying for children in more than one household, the income of the household with the lowest annual income after income deductions will be used to determine the family contributions.

The following are examples of premium calculations:

SCENARIO #1:
For example, a married applicant is applying for her own 7-year old child (Child 1) and her 6-month old stepchild (Child 2). The family size is 4 and the following individuals live in the home and have income:

Individuals living in the Home with Income:

1. Applicant ($1500/monthly earned income after applicable deduction);
2. Applicant's Spouse ($2000/monthly earned income after applicable deduction);
3. Child 1 (Applicant's own separate child/Spouse's step-child) ($600/monthly child support income after applicable deduction);
4. Child 2 (Spouse's own separate child/Applicant's step-child) ($700/monthly child support income after applicable deduction)

Child 1's MBU, Whose income is used to determine Child 1's eligibility:
Child 1 determined eligible for the HFP.
Applicant's $1500/monthly
Child 1's $600/monthly

Child 2's MBU, Whose income is used to determine Child 2's eligibility:
Child 2 determined ineligible, as a result of income being below the HFP guidelines.
Applicant's Spouse $2000/monthly
Child 2's $700/monthly

Monthly Premium Assessment (use all income applied in any child's MBU [within a MFBU/household] who's applying for coverage). Income used to determine HFP monthly premium amount is based on the following:

Applicant's $1500/monthly
Applicant's Spouse $2000/monthly
Child 1's $600/monthly
Child 2's $700/monthly

Total Income Used to Determine Monthly Premium Amount for Household is $4,800.
(For a family size of 4, this income amount falls within Category B.)

SCENARIO # 2:
For example, an applicant is applying for her three children who are half-siblings. Child 1 is 15 years old, Child 2 is 5 years old, and Child 3 is a 6-month old baby. The family size is 4 and the following individuals live in the home and have income:

Individuals living in the Home with Income:

1. Applicant ($2500/monthly earned income after applicable deduction);
2. Child 1 ($1000/monthly child support after applicable deduction & $600/monthly gift income);
3. Child 2 ($500/monthly child support after applicable deduction);
4. Child 3 ($400/monthly child support after applicable deduction)

Child 1's MBU, Whose income is used to determine Child 1's eligibility:

Child 1 determined ineligible for the HFP as a result of the income being above the HFP guidelines.
Applicant's $2500/monthly
Child 1's $1000/monthly child support
Child 1's $600 monthly gift income

Child 2's MBU, Whose income is used to determine Child 2's eligibility:
Child 2 determined eligible for HFP.
Applicant's $2500/monthly
Child 2's $500/monthly

Child 3's MBU, Whose income is used to determine Child 3's eligibility:
Child 3 determined ineligible for the HFP, as a result of the income being below the HFP guidelines.
Applicant's $2500/monthly
Child 3's $400/monthly

Monthly Premium Assessment (use all income applied in any child's MBU [within an MFBU/household] who's applying for coverage). Income used to determine HFP monthly premium amount is based on the following:

Applicant's $2500/monthly
Child 2's $500/monthly

Total Income Used to Determine Monthly Premium Amount for Household is $5,000.
(For a family size of 4, this income amount falls within Category B.)

27. Sponsorship:

A Family Contribution Sponsor is a person or entity who is registered with the MRMIB and who pays a family's premiums on behalf of an applicant for any 12 months in the program.

- Sponsorship can be initiated at any time during an enrollment period;
- If initial eligibility is denied a refund is generated to the sponsor with identifying family information;
- Once eligibility is established a sponsorship payment is non-refundable;
- Sponsorship payment will be applied to any past due amounts (within the last 12 months) on the account;
- No free months are earned;

- Sponsored families receive monthly billing statements indicating the sponsorship end date;

- A family may be sponsored more than once by the same or other sponsor;

- Premiums are not recalculated if a plan transfer occurs or if children are added (or disenrolled) from the case during the sponsorship period;

- Payment of less than 12 months will require follow-up with the sponsor;

- If a case is scheduled to receive a free month, start sponsorship after free month is applied.

28. Food Stamp Applications:

The Food Stamps application should be processed like a regular HFP application that is missing immigrant/citizenship documentation. The application should be sent to call back, and if otherwise eligible, the child(ren) should be enrolled, with the appropriate letter sent to the applicant stating the child is enrolled for two (2) months and that the required immigration/citizenship documentation needs to be received within the two-month period. If the applicant does not provide the required documentation within two (2) months of the enrollment date, and there is no acceptable birth record match with the State of California Department of Vital Statistics, disenrollment will be effective at the end of the 2nd full month of enrollment.

29. Transfers:

An applicant can request a transfer from one health, dental or vision plan to another. All transfer requests may be in writing or can be received over the phone. Transfers can be allowed in the following instances:

- An applicant can request a health plan, dental plan or vision plan transfer, one time for any reason, within the first three months from the original effective date of coverage in the Program. (Refer to Limited Dental Plan Choices section of the HFP Business Rules.); ***or***

- An applicant can request a health, dental or vision plan transfer, one time for any reason, within the first 30 days of the effective date of coverage in a new plan (including forced assignments) following Open Enrollment. (Refer to Limited Dental Plan Choices section of the HFP Business Rules.); ***or***

- An applicant's child moves out of the area served by the chosen plan and at least one other participating insurance plan serves the area in which the family or child

lives (i.e. current plan is not available in new address area). (Refer to Limited Dental Plan Choices section of the HFP Business Rules.); ***or***

- An applicant or the participating insurance plan requests in writing because the family or member and plan cannot establish a good relationship; ***and*** the Executive Director of the MRMIB determines that the transfer is the best interest of the child and the Program. (Refer to Limited Dental Plan Choices section of the HFP Business Rules.); ***or***

Health plan transfers will take effect within 40 days from the date the transfer is approved (always on the 1st of the month). When transfers between health plans occur, the monthly premium will be recalculated.

Children who go away to college shall continue with the same plans if available in their new residence. If the current plans are not available, the child may be transferred to an available plan located in both areas. The monthly premium will be based on the lower cost plan (if different from the other persons enrolled in the program).

With approval of MRMIB, persons temporarily out of the home may be transferred to a different plan than the other enrolled members of the household.

Healthy Families will notify the applicant in writing if and when there is a change in the monthly premium amount. A plan transfer will not change the premium amount paid by the sponsor.

If the Program learns that the child no longer resides in an area served by the chosen health, dental, or vision plans, Healthy Families will notify the applicant in writing to choose new plans in the new area of residence. The applicant must submit their new plan choice in writing to the HFP. However, if the applicant does not choose new plans within 30 days from the date of the written notice, Healthy Families will:

- Enroll the child in the Community Provider Plan as the health plan.
- Alternately assign the vision plan.
- Alternately assign the child into a limited dental plan, if limited dental plans are available. This is the case for families where a child was <u>not</u> enrolled in the HFP for 24 consecutive months <u>or</u> if the child is enrolled on or after 11/1/09, if limited dental plans are available. Twenty-four (24) consecutive months means that any child was continuously enrolled in the program during this period without a break in coverage. However, if the family had a child enrolled for 24 consecutive months or the child was enrolled before 11/1/09, then alternate assignment will occur for all dental plans (including Delta Dental and Premier Access) that participate in the county/zip code.

(Refer to Alternate Plan Assignment and Limited Dental Plan Choices section of the HFP Business Rules.)

30. Limited Dental Plan Choices, Effective November 1, 2009:

Families that did not have any child enrolled in the HFP for 24 consecutive months **or** any child enrolled prior to November 1, 2009 who continues to be enrolled, the child enrolled on or after November 1, 2009 has limited dental plan choices. Limited dental plans are other dental plans, which are not Delta Dental or Premier Access. Twenty-four (24) consecutive months means any child that was continuously enrolled in the program during this period without a break in coverage. The 24-month period is based on the effective date of coverage (and not the enrollment date).

Plan selections are based on a household level and all the HFP subscribers shall be in the same dental plan, unless a child lives at a different address (i.e. away at school) and the plans that the household level has is not available at the child's (away at school) address.

All dental plan transfer requests (i.e. non-Open Enrollment and Open Enrollment transfers) will be processed in accordance to the requirements identified in the Limited Dental Plan Choices section of the HFP Business Rules.

The following are the rules and exceptions:

Limited dental plan choice **does not** apply to children if:

1. Children enrolled into the Special Population Plan are not subject to the 24 consecutive months limited dental plan requirements, even if they were enrolled on or after November 1, 2009.
2. Children enrolled in the program before November 1, 2009 who continue to be enrolled in HFP.
3. Children enrolled in the program after November 1, 2009, where the family previously had a child enrolled in the program for 24 consecutive months.
    - If a family previously had any child enrolled in the HFP for 24 consecutive months, a family enrolling other new children in the program is not limited with their dental plan selections. The family can choose any dental plan that is available to them, even if the child that was previously enrolled in the HFP for 24 consecutive months is no longer enrolled.
    - If a child was previously enrolled in the program for 24 consecutive months and later is disenrolled, the child is not limited to dental plan choices at the time of re-enrollment, even if the re-enrollment occurs on or after November 1, 2009. The child already met the 24 consecutive month requirement.

4. Family resides in a county/zip code where no limited dental plans are available and the family has not been enrolled in the HFP for 24 consecutive months and moves to a new county/zip code area that now has a limited dental plan available. The family will be able to remain with the existing dental plan and will **not** be required to change to a limited dental plan.

   However, if their existing dental plan is not available in their new county/zip code, the applicant can select any dental plan (including Delta Dental or Premier Access) that is available.

5. Family enrolled (on or after November 1, 2009) into a limited dental plan and has not been enrolled for 24 consecutive months. Family moves to new county/zip code where no limited dental plans are available. Child can transfer into any available dental plan (including Delta Dental or Premier Access) in their new county/zip code.

6. Add-A-Person enrolled into an existing case, where the existing family member was not enrolled in the HFP for 24 consecutive months. Existing family member was enrolled prior to November 1, 2009. Existing family member is with a limited dental plan (i.e. not Delta Dental or Premier Access). Add–A-Person is enrolled into the same dental plan. Existing family member is disenrolled (i.e. eligible for No-Cost Medi-Cal at Annual Eligibility Review). Add-A-Person will remain with limited dental plan (i.e. not Delta Dental or Premier Access) and continues to be enrolled. During the Open Enrollment process, child can transfer to either Delta Dental or Premier Access if the plans are available in the county/zip code.

Limited dental plan choice will **apply** to children if:

1. Family did not previously have any child enrolled in the HFP for 24 consecutive months and children are now enrolling on or after November 1, 2009. The enrollment did not occur as a result of an Add A Person when an existing child was enrolled prior to November 1, 2009.
2. Children were previously enrolled in the program, but were not enrolled for 24 consecutive months. Children are disenrolled and later re-enroll back into the HFP. The Re-enrollment for the children occurs on or after November 1, 2009. Because the family did not previously have any child enrolled in the HFP for 24 consecutive months and re-enrollment occurs after November 1, 2009, the children are limited to certain dental plan choices.
3. Family enrolled into a limited dental plan where no child has been enrolled for 24 consecutive months. Family moves to a new county/zip code where existing limited dental plan is not available but another limited dental is available. The family must transfer into any available limited dental plan in the new county/zip code area.

4. Add-A-Person enrolled into an existing case, where the existing family member was not enrolled for 24 consecutive months (however, existing child was enrolled prior to November 1, 2009). Existing family member was enrolled in Delta Dental or Premier Access. Existing family member is disenrolled (i.e. age 19). Add-A-Person can remain with either Delta Dental or Premier Access. If Add-A-Person is disenrolled for any reason and is later re-enrolled, this child will be subjected to the limited dental plan choice requirement at the time of re-enrollment, if the child was not previously enrolled in the HFP for 24 consecutive months.

Scenario 1:

10/31/09 – Family or at least one member is disenrolled from HFP (previously enrolled for 24 consecutive months).
11/10/09 – Family submits documentation to Re-Enroll into HFP.
11/16/09 – Child(ren) are determined eligible and enrolled into HFP. Family can re-enroll in any available dental plan choice.
11/26/09 - Coverage begins for family (i.e. Effective Date).

Scenario 2:

10/15/08 - 10/31/09 Family is enrolled in HFP with no lapse in coverage. Family not enrolled for 24 consecutive months.
11/10/09 -Family submits Re-Enrollment Form and resides in a county that has limited dental plans available.
11/15/09 - Family is determined eligible and enrolled into HFP in a limited dental plan, even though they were previously enrolled in either Delta Dental or Premier Access.
11/25/09 -Coverage begins for family (i.e. Effective Date). The 24 consecutive month period starts here.

Scenario 3:

10/15/04 – 10/31/07 Family is enrolled in HFP with no lapse in coverage. Family met the 24-consecutive month requirement.
11/10/09 – Family submits an application and selects either Delta Dental or Premier Access and resides in a county that also has limited dental plans available.
11/22/09 – Family is determined eligible and enrolled into HFP in Delta Dental or Premier Access because there was a child previously enrolled for 24 consecutive months.
12/02/09 – Coverage begins for the family (i.e. Effective Date).

Scenario 4:

10/15/09 – 12/31/09 Family is enrolled in HFP. Family not enrolled for 24 consecutive months.
1/11/10 - Family submits a Re-Enrollment Form and resides in a county that has limited dental plans available.

1/15/10 -Family is determined eligible and enrolled into HFP in a limited dental plan.
1/25/10 -Coverage begins for the family (i.e. Effective Date). The 24 consecutive month period starts here.

Scenario 5:

10/15/09 -Family is enrolled in HFP. Family not enrolled for 24 consecutive months.
11/10/09 -Family submits an Add-A-Person Form.
11/14/09 -New child is determined eligible and enrolled in the existing children's dental plan that is not Delta Dental or Premier Access.
11/24/09 -Coverage begins for the new child (i.e. Effective Date).
12/12/09 -Family submits plan transfer request within 3 months of existing children's enrollment and wants to switch to Delta Dental or Premier Access.
12/20/09 -Transfer request is processed and dental plan change request to either Delta Dental or Premier access is approved, due to a subscriber in the household being enrolled before November 1, 2009, prior to the limited dental plan choice requirement being effective.

Scenario 6:

11/15/09 –New family is enrolled in HFP in a limited dental plan.
11/25/09 -Coverage begins for the new child (i.e. Effective Date). The 24 consecutive month period starts here.
12/11/09 -Family submits plan transfer request within first 3 months of enrollment and wants to switch to either Delta Dental or Premier Access.
12/18/09 -Transfer request is processed and denied (since there were no members in the household that was enrolled before the limited dental plan choice requirement was effective and no child in the household that was enrolled for 24 consecutive months).

Scenario 7:

10/01/09 – Child A is enrolled in HFP into a limited dental plan (i.e. not a Delta Dental or Premier Access). Family not enrolled for 24 consecutive months.
12/01/09 – Family submits an Add-A-Person Form.
12/11/09 – Add-A-Person (Child B) is determined eligible and enrolled into Child A's dental plan.
12/21/09 – Coverage begins for new child (i.e. Child B).
1/31/10 – Both children are disenrolled (i.e. Child A & Child B).
2/10/10 – Re-enrollment submitted for Child A. Family resides in a county that has limited dental plans available.
2/15/10 – Child A enrolled into a limited dental plan (since no child in the household was enrolled for 24 consecutive months).
2/25/10 – Coverage begins for Child A (i.e. Effective Date). The 24 consecutive month period starts here.

Scenario 8:

10/15/09 – Child A is enrolled in HFP into a limited dental plan. Family not enrolled for 24 consecutive months.

11/10/09 – Family submits Add-A- Person Form (i.e. Child B).
11/20/09 – Child B is determined eligible and enrolled in same plan as Child A.
12/1/09 – Coverage begins for Child B (i.e. Effective Date).
1/31/10 – Child A is disenrolled.
3/30/10 – Open Enrollment Form sent for Child B to enroll into Delta Dental or Premier Access.
5/10/10 – Child B transfer approved to enroll into Delta Dental or Premier Access, since Child B was added to a case where a subscriber in the household was enrolled prior to November 1, 2009.

Scenario 9:

10/15/09 – Child A is enrolled in HFP in Delta Dental or Premier Access. Family not enrolled for 24 consecutive months.
11/10/09 – Family submits Add-A-Person Form for Child B.
11/20/09 – Child B determined eligible and enrolled in same plan as Child A.
11/30/09 – Coverage begins for Child B (i.e. Effective Date).
1/31/10 – Child A is disenrolled, however, Child B continues to be enrolled same dental plan.
3/01/10 – Add-A-Person Form is received for Child C.
3/10/10 – Child C is determined eligible and enrolled in same dental plan as Child B.
3/20/10 – Coverage begins for Child C.
3/30/10 – Open Enrollment Form sent for Child B and C to enroll into Delta Dental or Premier Access.
5/10/10 – Child B and Child C transfer approved to enroll into Delta Dental or Premier Access, since Child B was added to a case where a subscriber in the household was enrolled prior to November 1, 2009.

Scenario 10:

10/01/07 – 10/31/09 Family is enrolled in HFP with no lapse in coverage with Delta Dental or Premier Access. Family met the 24-consecutive month requirement.
10/31/09 – Family is disenrolled from HFP.
11/15/09 – Child A submits Re-Enrollment Form with an Add–A-Person Form for Child B.
11/25/09 – Both children are enrolled in Delta Dental or Premier Access, which was the previous dental plan for Child A. Although Child B is new, they are not limited with dental plan choices, since Child A was previously enrolled for 24 consecutive months.
12/05/09 – Coverage begins for both children (i.e. Effective Date).

Scenario 11:

10/01/07 – 10/31/09 Child A is enrolled in HFP with no lapse in coverage. Family met the 24-consecutive month requirement.
11/01/09 – Family submits Add-A-Person Form for Child B.
11/10/09 – Child B determined eligible and enrolled in same dental plan as Child A.
11/20/09 – Coverage begins for Child B (i.e. Effective Date).
1/31/10 – Child A & B are disenrolled

2/05/10 – Child B submits an application and resides in a county that has limited dental plans available. Family selects Delta Dental or Premier Access.
2/15/10 – Child B is granted enrollment into Delta Dental or Premier Access because there was a child previously enrolled for 24-consecutive months.
2/25/10 – Coverage begins for Child B (i.e. Effective Date).

Scenario 12:

10/1/09 – Child is enrolled in HFP. There were limited dental plans available, but family selected Delta Dental or Premier Access.
10/11/09 – Coverage begins (i.e. Effective Date).
*10/15/10 – AER is submitted for child and is determined ITL
10/31/10 – Child is disenrolled from HFP and is granted Presumptive Eligibility into No-Cost Medi-Cal.
1/05/11 – Re-enrollment Form submitted for child.
1/15/11 – Child is determined eligible for HFP. However, child can only re-enroll into limited dental plans, if they are available. Child subjected to 24-consecutive month requirement.
1/25/11 – Coverage begins for child (i.e. Effective Date). The 24 consecutive month period starts here.

* If AER was submitted on the 2nd consecutive year of coverage and child disenrolled, child fulfilled the 24-consecutive month requirement for the Limited Dental Plan Choice. In this case, child can select any available dental plan (including Delta Dental or Premier Access) upon re-enrollment.

Scenario 13:

5/01/09 – Child A is the first child enrolled on a case. They are enrolled in Limited Dental Plan Choice. However, they are exempt from the limited dental plan choice rules because they are enrolled prior to 11/1/09. Family not enrolled for 24 consecutive months.
5/11/09 – Coverage begins for Child A.
11/28/09 – An Add A Person is processed for Child B. They are enrolled into the same plan as their sibling.
11/30/09 – Child A is disenrolled per applicants request.
*12/08/09 – Coverage begins for Child B (i.e. Effective Date).

*Child B will NOT have a limited dental plan selection if they transfer plans or want to transfer to Delta or Premier Access at OE (or non-OE transfer process). Child B will not be limited because Child B's enrollment occurred while Child A was enrolled in HFP (enrollment for Child A occurred before 11/1/09; therefore family is exempt at this time). However, if Child B is later disenrolled (i.e. 5/31/10) and later re-enrolls back into the HFP, because Child B was not enrolled in the program for 24 consecutive months and no other child in the family was previously enrolled for 24 consecutive months, then, Child A's and/or Child B's, or any other children's re-enrollment will be subjected to the limited dental plan choice.

Scenario 14:

12/01/09 – New child is determined eligible and enrolled into HFP. Family enrolled into a limited dental plan. Family did not have any children previously enrolled in HFP for 24 consecutive months.
12/11/09 – Coverage begins for the family (i.e. effective date). The 24 consecutive month period starts here.
11/30/11 – Family is disenrolled for non-payment of premiums.
12/29/11 – Family submits re-enrollment form.
01/05/12 – Family is determined eligible and is subjected to enroll into a limited dental plan.
01/15/12 – Coverage begins for family (i.e. effective date). The 24 consecutive month period re-starts here, again.

Scenario 15:

11/01/09 – New child is determined eligible and enrolled into HFP. Family enrolled into a limited dental plan. Family did not have any children previously enrolled in the HFP for 24 consecutive months.
11/11/09 – Coverage begins for the family (i.e. effective date). The 24 consecutive month period starts here.
12/20/09 – Family moves to a different county where current dental plan is not available but does offer other limited dental plan selections.
01/19/10 – Family did not choose another dental plan so a limited dental plan is assigned through the Alternate Plan Assignment process.
02/01/10 – New limited dental plan coverage begins.

Scenario 16:

11/01/09 – New child is determined eligible and enrolled into HFP. Family enrolled into a limited dental plan. Family did not have any children previously enrolled in the HFP for 24 consecutive months.
11/11/09 – Coverage begins for the family (i.e. effective date). The 24 consecutive month period starts here.
12/20/09 – Family moves to a different county where current dental plan is not available but does offer other limited dental plan selections.
01/01/10 – Family chooses another dental plan (i.e. Delta Dental or Premier Access) that is not a limited dental plan.
01/11/10 – Family's Dental plan selection is denied.
01/19/10 – Family did not choose another dental plan so a limited dental plan is assigned through the Alternate Plan Assignment process.
02/01/10 – New dental plan coverage begins.

Scenario 17:

11/05/09 – New child is determined eligible and enrolled into HFP. Family enrolled into a limited dental plan. Family did not have any children previously enrolled in the HFP for 24 consecutive months.
11/15/09 – Coverage begins for the family (i.e. effective date). The 24 consecutive

month period starts here.
12/23/09 – Family moves to a different county and zip code area where current dental plan is not available and the new county and zip code area does **not** offer any limited dental plans. For example, only Delta Dental or Premier Access is available in the new county/zip code area.
01/22/10 – Family did not choose another dental plan so any available dental plan is assigned through the Alternate Plan Assignment process.
03/01/10 – New dental plan coverage begins.

Scenario 18:
10/30/09 – Child is determined eligible and enrolled into HFP. Family enrolled into a limited dental plan. Family did not have any children previously enrolled in the HFP for 24 consecutive months.
11/10/09 – Coverage begins for the family (i.e. effective date). The 24 consecutive month period starts here.
12/20/09 – Family moves to a different county and zip code area where current dental plan is not available and the new county and zip code area does offer other limited dental plans.
01/19/10 – *Family did not choose another dental plan so any available dental plan is assigned through the Alternate Plan Assignment process.
02/10/10 – New dental plan coverage begins.

*Although the family's effective date was after 11/01/09, the family was not subjected to choosing a limited dental plan, since they were determined eligible and enrolled prior to 11/01/09.

Scenario 19
10/30/09 – Child is determined eligible and enrolled into the HFP. Family not subjected to limited dental plan choices. Family enrolls in Premier Access. Family did not previously have any child enrolled in HFP for 24 consecutive months.
11/10/09 – Coverage begins for the family (i.e. Effective Date). The 24 consecutive months starts here.
01/03/10 – Family moves to a new county/zip code area that does not have Premier Access as an available dental plan. Family chooses Delta Dental plan, which is available in new county/zip code, even though other dental plans are available.
01/15/10 – Transfer request to Delta Dental approved, because child was previously enrolled in a non-limited dental plan (i.e. Premier Access).
02/01/10- Transfer effective date begins with Delta Dental.
04/30/10 – Child disenrolled from HFP.
05/15/10 – *Family re-applies for child by submitting Re-enrollment form, via HeA or new application. Family identifies Delta Dental as dental plan choice, even though limited dental plan choices are available.

05/25/10 – Family did not choose a valid dental plan (since they are subjected to 24 consecutive month period), therefore a limited dental plan is assigned through the Alternate Plan Assignment process.
06/05/10 – Coverage begins for the family (i.e. Effective Date). Child enrolled with limited dental plan. The 24 consecutive month period re-starts here again.

* Because child was not previously enrolled in HFP for 24 consecutive months and the family did not have any child previously enrolled for 24 consecutive months, the child is subjected to limited dental plan choice at the time of re-enrollment.

31. Plan Cap & Dental Closure Rules:

Plan Cap:

The Administrative Vendor must monitor the plan caps by region at an interval determined by MRMIB.

- While we are moving toward the enrollment caps, ALL enrollments are counted toward the cap (including validation forms and siblings).

- Validation Forms are developed by the plans as a means to keep their known members (at their discretion). Validation Forms have been developed in a triplicate format; one copy for the plans to keep; one copy for the member to keep for their records; one copy to send into the HFP to override a cap and enroll. The original Validation Form must be mailed in; HFP is NOT to accept copies or faxes of this form (plan rules). The Administrative Vendor is to scan the plan Validation form in as part of the applicant's record/file. The HFP does not forward the Validation Forms back to the plans.

- When MRMIB notifies the Administrative Vendor that a region is closed the only way to enroll is with a validation form or when a new sibling is being added to an existing active case in which children are already enrolled.

- The plan retains a copy of each Validation Form they issue.

Dental Closure Rules:

- Counties in which a plan is NOT an available dental plan to new members is attributable to Delta NOT meeting the family value package (FVP). Therefore, if and when a county is closed to new enrollment, the county closure for new members is effective on the date the new rate goes into effect, not when a specified number of members are enrolled. Exception to this county closure rule is the enrollment of siblings to an existing active case in which children are already enrolled in the plan.

- The Administrative Vendor will need to have the capability to close and OPEN counties to new enrollment at the direction of the State. In addition to the possibilities of Dental plan closing new enrollment to other counties, it is conceivable that there may come a time in which the dental plan opens a previously closed county. The Administrative Vendor will need to have the ability to close and open counties as directed and also document the date in which a county is closed and/or open.

32. Continued Enrollment, Appeal, Program Review, Reinstatement, & Re-enrollment Glossary of Definitions and Procedures:

- Continued Enrollment (CE): A person continues enrollment in the HFP subsequent to a disenrollment decision and notification. A case is granted CE if the request is returned on or before the disenrollment date. CE extends the enrollment period for one month or until the end of the month in which the appeal decision is completed. Granting (approving) CE is independent of the decision to approve or deny the appeal. After reviewing the CE request, the HFP may determine that the request does not meet the requirements of an appeal and therefore, the request is processed as a Program Review.

- Appeal: An appeal is based upon a written statement from the applicant or authorized representative who disagrees with an eligibility, disenrollment, or effective date of coverage decision made by the HFP. To consider the written statement as an appeal it must be received within 60 days of the HFP decision. The statement is not considered an appeal if it solely requests a review of new information. The HFP shall complete its review and send notification of the decision within 15 business days of receipt of the appeal.

- Program Review: Generally, a written statement from the applicant who submits new information for review to the HFP. The new information is received within 60 days of the HFP decision to disenroll or ineligible for HFP. A Program Review is also a statement that would have otherwise been considered an appeal but is submitted more than 60 days after the HFP decision. The HFP shall complete its review and send notification of the decision within 15 business days of receipt of the review request.

- Re-enrollment: Generally, occurs when HFP made a correct decision and subsequently the applicant provides new information for review after disenrollment. The new information makes the person eligible for HFP. If the person passes file clearance, HFP coverage starts again with a break in coverage; the AER date changes. The account must be current.

- Appeal Rights:

  - ✓ 1st level review – The appeal is reviewed and a decision is made by the HFP about the original action to disenroll, deny enrollment or effective date of

coverage. The appeal must be received within 60 calendar days from the decision being appealed.

- ✓ 2nd level review – The appeal is reviewed and a decision is made by the MRMIB about the original action and the 1st level review. The appeal must be received within 30 calendar days from the decision being appealed.

- Upon receipt of a Program Review or correspondence in which the applicant requests a review of a decision made by the HFP, the HFP is instructed to take the following actions:

  - ✓ Request is received within 60 days of the decision; review the request:

    1. If the request is an appeal and HFP made an incorrect decision or delayed eligibility determination, reinstate the case (if received within 30 days of disenrollment). Applicant receives further rights to a 2nd level review.

    2. If the request is an appeal and HFP made a correct decision, case remains denied or disenrolled. Deny the appeal. Applicant receives further rights to a 2nd level review.

    3. If the request is not an appeal, new information was received, review the documentation and make a NEW eligibility determination. If the new information makes the person eligible, re-enroll the case. The applicant receives 1st level appeal rights on the decision based on the new information.

- Upon receipt of correspondence in which the applicant requests a review of a decision made by the HFP AND the subscriber is on no-cost Medi-Cal Presumptive Eligibility (PE), the HFP is instructed to take the following actions:

  - ✓ Request is received while the subscriber is on PE; review the request:

    1. If the request is an appeal and HFP made an incorrect AER decision, reinstate the case. Applicant receives further rights to a 2nd level review. During the monthly MEDS process, PE will end.

    2. If the request is an appeal and HFP made a correct AER decision, deny the appeal, subscriber will remain on PE. Applicant receives further rights to a 2nd level review.

    3. If the request is not an appeal, new information was received, review the documentation and make a NEW eligibility determination. If the new information makes the person eligible, re-enroll the case effective 10 calendar days from the decision. During the monthly MEDS process, PE

will end. The applicant receives 1st level appeal rights on the decision based on the new information.

- ✓ Request is received while subscriber is still enrolled in HFP:

  1. If the request is an appeal and HFP made an incorrect AER decision, re-enroll the case effective on the 1st of the month following the end of the month of the anniversary date. Applicant receives further rights to a 2nd level review. During the monthly MEDS process, PE will end.

  2. If the request is an appeal and HFP made a correct AER decision, deny the appeal and maintain the end of coverage date Applicant receives further rights to a 2nd level review.

  3. If the request is not an appeal, new information was received, review the documentation and make a NEW eligibility determination. If the new information makes the person eligible, re-enroll the case effective the 1st day of the month following the end of the anniversary date. The applicant receives 1st level appeal rights on the decision based on the new information. During the monthly MEDS process, PE will end.

- ✓ In any of the above situations, if the applicant is requesting payment of medical bills as a result of a break in coverage, process the case as instructed, log in the database, and forward to MRMIB. In situations where a case was previously referred to the county and the new information received results in an enrollment, the new information is also forwarded to the county of residence.

33. Alternate Plan Assignment (implemented January 2007):

When plan information is unidentified or identified but not available in the client's county/zip code, the HFP will continue to collect the applicant's plan selection(s) through the missing information (MI) process. Existing business rules for missing information will be followed to include required letters and phone calls. If the applicant does not provide or provides an unavailable plan, a plan will be assigned by the 20th calendar day from the date in which the HFP received the application. Once the plans are assigned in order to make the application complete, the HFP will make an eligibility determination**.** Children who are eligible for the HFP will be enrolled within 3 business days from the date the plans are assigned with a future effective date. (Refer to Limited Dental Plan Choices section of the HFP business rules)

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1. When the health plan is unidentified or identified but not available in the client's county/zip code and there is more than one health plan available, the system will always default the health plan to the Community Provider Plan (CPP) in the

county/zip code. If the CPP is not available in the client's county/zip code, the system will automatically assign the health plan through an alternate plan assignment process. If only one health plan is available, that plan will be assigned. Only active plans are to be considered for automatic/alternate assignment, which are available in the county/zip code of the client. Eligible clients with missing information for only health plan will be enrolled in the program after the system CPP default process is completed.

2. When the dental plan is unidentified or identified but not available in the client's county/zip code and there is more than one dental plan available, the system will automatically assign the dental plan through an alternate plan assignment process. If only one dental plan is available, that plan will be assigned. Only active plans are to be considered for automatic/alternate assignment, which are available in the county/zip code of the client. Eligible clients with missing information for only dental plan will be enrolled in the program after automatic assignment process is completed. Certain children will not be allowed to be automatically assigned into certain dental plans (i.e. Delta Dental or Premier Access).

   - Families that did not have any child enrolled in the HFP for 24 consecutive months **or** the child was enrolled on or after November 1, 2009 has limited dental plan choices. Therefore, the alternate plan assignment process must not select Delta Dental or Premier Access, if other dental plans are available in the child's county/zip code.

   - Families that did not have any child enrolled in the HFP for 24 consecutive months **or** the child was enrolled on or after November 1, 2009 who reside in a county/zip code that does not have limited dental plans available, can be alternately assigned to any dental plan (including Delta Dental or Premier Access) available in their county/zip code area.

   Twenty-four (24) consecutive months means that any child was continuously enrolled in the program during this period without a break in coverage. (Also refer to Limited Dental Plan Choices section of the HFP Business Rules.)

3. When the vision plan is unidentified or identified but not available in the client's county/zip code and there is more than one vision plan available, the system will automatically assign a vision plan through an alternate plan assignment process. If only one vision plan is available, that plan will be assigned. Only active plans are to be considered for automatic/alternate assignment, which are available in the county/zip code of the client. Eligible clients with missing information for only vision plan will be enrolled in the program after automatic assignment process is completed.

4. Plan coverage is to be matched to the client's county/zip code coverage. Residential client address is to be used if one exists, if not use case residential address. The automatic/alternate assignment of plans is to be triggered by the

20th calendar day (from the application receipt date at the HFP) for the clients who have not identified any plans in their application or identified an unavailable health, dental and/or vision plan in the county/zip code. For alternate assignment of plans, when there is more than one Vision or Dental plan available in the clients' county/zip code, plans will be alternately selected among the plans that cover the county/zip code. Only active plans are to be considered for automatic/alternate assignment, which are available in the county/zip code of the client. All closed plans for the county/zip code are to be ignored. Limited dental plan selections shall be factored into the automatic/alternate plan assignment process as follows:

- Families that did not have any child enrolled in the HFP for 24 consecutive months **or** the child was enrolled on or after November 1, 2009 has limited dental plan choices. Therefore, the alternate plan assignment process must not select Delta Dental or Premier Access, if other dental plans are available in the child's county/zip code.

- Families that did not have any child enrolled in the HFP for 24 consecutive months **or** the child was enrolled on or after November 1, 2009 who reside in a county/zip code that does not have limited dental plans available, can be alternately assigned to any dental plan (including Delta Dental or Premier Access) available in their county/zip code area.

- Families that did not have any child enrolled in the HFP for 24 consecutive months **and** were enrolled on or after November 1, 2009 who originally lived in a county that did not have any limited dental plans available. At the time of enrollment, the children were enrolled in a dental plan that was available to them, such as Delta Dental or Premier Access. The family later moves to another county/zip code that does not have their existing dental plan available to them. During the alternate plan assignment process; the children may be assigned to any dental plan that is available in their new county/zip code area, including Delta Dental or Premier Access.

(Also, refer to Limited Dental Plan Choices section of the HFP Business Rules.)

5. The missing information letter will include information about automatic assignment of plans if no choice is provided by the due date.

6. Welcome Letter will include information about the automatic plan assignment and shall provide information that, within 3 months of the child's effective date of coverage, the applicant may request for a plan transfer. Additional verbiage is to be added to only the clients for whom the plan has been automatically/alternately assigned.

7. Missing information phone scripts will be revised and include information regarding the automatic assignment of plans if no choice is provided by the due date.

8. General information phone scripts will answer common questions after the health/dental/vision plans are automatically assigned.

9. Welcome Letter will exclude the information listed in Item #6 above for Add-A-Person or Re-Enrollment applications where the applicants have existing children enrolled in the HFP. When the new client for Add-A-Person is automatically assigned, assignment will be to the same plans as existing family members, so long as the client's residential address is covered by the existing family members' plans.